FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011643

Facility Name: SUNSET HOME

Address: 418 WASHINGTON (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: 217-223-2636 **Fax #** 217-223-9867

IDPA ID Number: 370661224-001

Date of Initial License for Current Owners: NOT AVAILABLE

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: RUTH STOWE **Telephone Number:** 217-223-2636 EXT 311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/02 to 09/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 12/01/2003 (Date)
(Type or Print Name) JUDY KIRLIN
(Title) CEO/ADMINISTRATOR

Paid Preparer

(Signed) 12/01/2003 (Date)
(Print Name and Title) TIMOTHY WIEWEL, PROPRIETOR
(Firm Name & Address) TIMOTHY J WIEWEL CPA, PO BOX 1028 QUINCY IL 62306
(Telephone) 217-223-2245 Fax # 217-223-7580

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 248

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	6,935	1
2		Skilled Pediatric (SNF/PED)			2
3	148	Intermediate (ICF)	148	54,020	3
4		Intermediate/DD			4
5	81	Sheltered Care (SC)	81	29,565	5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	90,520	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	114	32	2,546	2,692	8
9	SNF/PED					9
10	ICF	30,519	22,683		53,202	10
11	ICF/DD					11
12	SC	12,605	2,525		15,130	12
13	DD 16 OR LESS					13
14	TOTALS	43,238	25,240	2,546	71,024	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.46%

D. How many bed-hold days during this year were paid by Public Aid? ____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
INDEPENDENT LIVING UNITS, SENIOR APARTMENTS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 2,546

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: ____ Fiscal Year: ____

* All facilities other than governmental must report on the accrual basi

STATE OF ILLINOIS

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/01/02 **Ending:** 09/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	517,711	33,882	9,309	560,902		560,902		560,902			1
2	Food Purchase		241,189		241,189		241,189		241,189			2
3	Housekeeping	241,175	39,825		281,000		281,000		281,000			3
4	Laundry	42,412	(13,140)	122,862	152,134		152,134		152,134			4
5	Heat and Other Utilities			301,964	301,964		301,964		301,964			5
6	Maintenance	176,141	36,764	72,817	285,722	(567)	285,155		285,155			6
7	Other (specify):*											7
8	**TOTAL General Services**	977,439	338,520	506,952	1,822,911	(567)	1,822,344		1,822,344			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,200,871	142,728	40,484	3,384,083		3,384,083		3,384,083			10
10a	Therapy	221,611	4,807	176,809	403,227		403,227		403,227			10a
11	Activities	126,317	6,815	5,573	138,705		138,705		138,705			11
12	Social Services	89,186	161	2,229	91,576		91,576		91,576			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,637,985	154,511	225,095	4,017,591		4,017,591		4,017,591			16
	C. General Administration											
17	Administrative	79,007			79,007		79,007		79,007			17
18	Directors Fees											18
19	Professional Services			45,718	45,718		45,718	(495)	45,223			19
20	Dues, Fees, Subscriptions & Promotion			50,317	50,317		50,317	(10,441)	39,876			20
21	Clerical & General Office Expense	293,303	10,222	104,825	408,350		408,350		408,350			21
22	Employee Benefits & Payroll Taxe			1,295,999	1,295,999	(11,984)	1,284,015		1,284,015			22
23	Inservice Training & Educatior			1,607	1,607		1,607		1,607			23
24	Travel and Seminar			19,140	19,140		19,140	(5,757)	13,383			24
25	Other Admin. Staff Transportatio											25
26	Insurance-Prop.Liab.Malpractice			129,059	129,059		129,059		129,059			26
27	Other (specify):* **BAD DEBT**			2,768	2,768		2,768	(2,768)				27
28	**TOTAL General Administration**	372,310	10,222	1,649,433	2,031,965	(11,984)	2,019,981	(19,461)	2,000,520			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,987,734	503,253	2,381,480	7,872,467	(12,551)	7,859,916	(19,461)	7,840,455			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SUNSET HOME #0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			415,729	415,729	(52,260)	363,469		363,469			30
31	Amortization of Pre-Op. & Org											31
32	Interest			28,179	28,179	(25,238)	2,941	(764)	2,177			32
33	Real Estate Taxes					567	567		567			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			443,908	443,908	(76,931)	366,977	(764)	366,213			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,910		36,910		36,910		36,910			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,433	91,433		91,433		91,433			42
43	Other (specify):* SEE ATTACHED			156,428	156,428	89,482	245,910	(245,910)				43
44	**TOTAL Special Cost Centers**		36,910	247,861	284,771	89,482	374,253	(245,910)	128,343			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,987,734	540,163	3,073,249	8,601,146		8,601,146	(266,135)	8,335,011			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Incom				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salar				12
13	Sales Tax				13
14	Non-Care Related Interes	(764)	32		14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,500)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer	(495)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,768)	27		24
25	Fund Raising, Advertising and Promotiona	(91,443)	43		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE 5A	(164,165)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (266,135)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organizatio Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (266,135)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SUNSET HOME

ID# 0011643

Report Period Beginning: 10/01/02

Ending: 09/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IDPA PREPAID LICENSE FEE	$ (3,480)	20	1
2	PREPAID WORKERS BACKGROUND CHECKS	(461)	20	2
3	OUT OF STATE TRANSPORTATION SEMINAR	(7,223)	24	3
4	VILLA APARTMENTS	(79,273)	43	4
5	SUNSET APARTMENTS	(75,194)	43	5
6	SEMINAR FEES PAID FY 2002 FOR FY 2003	1,466	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(164,165)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/01/02 **Ending:** 09/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(495)	0	0	0	0	0	0	0	0	0	0	(495)	19
20	Fees, Subscriptions & Promotions	(10,441)	0	0	0	0	0	0	0	0	0	0	(10,441)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,757)	0	0	0	0	0	0	0	0	0	0	(5,757)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,768)	0	0	0	0	0	0	0	0	0	0	(2,768)	27
28	**TOTAL General Administration**	(19,461)	0	0	0	0	0	0	0	0	0	0	(19,461)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,461)	0	0	0	0	0	0	0	0	0	0	(19,461)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/01/02 **Ending:** 09/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(764)	0	0	0	0	0	0	0	0	0	0	(764)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(764)	0	0	0	0	0	0	0	0	0	0	(764)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(245,910)	0	0	0	0	0	0	0	0	0	0	(245,910)	43
44	**TOTAL Special Cost Centers**	(245,910)	0	0	0	0	0	0	0	0	0	0	(245,910)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(266,135)	0	0	0	0	0	0	0	0	0	0	(266,135)	45

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MERCANTILE		X	OPERATIONS LINE OF CREDIT		12/21/2000	$	$	12/21/2007	0.0425	$ 2,177	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 2,177	9
	B. Non-Facility Related*											
10	GIFT ANNUITIES		X	NONE							764	10
11	MERCANTILE		X	PURCHASE APARTMENTS		7/28/2003	2,000,000	2,000,000	1/28/2004	0.0500	17,778	11
12	MERCANTILE		X	PURCHASE APART LOC				1,001,084	12/21/2007	0.0043	7,460	12
13												13
14	TOTAL Non-Facility Related						$ 2,000,000	$ 3,001,084			$ 26,002	14
15	TOTALS (line 9+line14)						$ 2,000,000	$ 3,001,084			$ 28,179	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2002 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	567	2
3. Under or (over) accrual (line 2 minus line 1).	$	567	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru	$	567	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001	552	11
2002	567	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNSET HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT RUTH STOWE

TELEPHONE 217-223-2636 EXT 311 FAX #: 217-223-9867

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-2-0917-000-00	700 S 5TH	$ 79.82	$ 79.82
2.	23-2-0973-000-00	810 S 4TH	$ 37.44	$ 37.44
3.	23-2-0972-000-00	812 S 4TH	$ 292.44	$ 292.44
4.	23-2-0926-000-00	701 S 4TH	$ 157.52	$ 157.52
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 567.22	$ 567.22

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 144,818 B. General Construction Type: Exterior BRICK Frame STELL-FIREPROOF Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

VILLA APRTMENTS 16 - 2 BEDROOM UNITS 16,000 SG FT

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	199,487		$ 102,419	1
2	PARKING LOT ADDITIONAL	15,000	1996-97	86,288	2
3	TOTALS	214,487		$ 188,707	3

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	34		1958	1958	$ 354,000	$ 7,080	50	$ 7,080	$	$ 322,140	4
5	117		1971	1971	1,218,562	24,371	50	24,371		779,852	5
6	49		1972	1972	472,577	9,452	50	9,452		300,092	6
7	5		1987	1987	68,497	3,425	20	3,425		55,085	7
8	43		2001	2001	2,500,281	83,343	30	83,343		166,685	8
	Improvement Type**										
9	BUILDINGS & IMPROVEMENTS			1958	12,000		10			12,000	9
10	BUILDINGS & IMPROVEMENTS			1972	51,124	1,023	50	1,023		31,704	10
11	BUILDINGS & IMPROVEMENTS			1977	14,179		20			14,179	11
12	BUILDINGS & IMPROVEMENTS			1978	442,103	8,842	50	8,842		225,587	12
13	BUILDINGS & IMPROVEMENTS			1979	13,639	273	50	273		6,686	13
14	BUILDINGS & IMPROVEMENTS			1980	771		20			771	14
15	BUILDINGS & IMPROVEMENTS			1981	7,902		10			7,902	15
16	BUILDINGS & IMPROVEMENTS			1982	13,900		10			13,900	16
17	BUILDINGS & IMPROVEMENTS			1983	17,260	588	20	588		17,260	17
18	BUILDINGS & IMPROVEMENTS			1985	272,013	6,800	40	6,800		124,549	18
19	BUILDINGS & IMPROVEMENTS			1987	321,886	14,347	10,20	14,347		272,839	19
20	BUILDINGS & IMPROVEMENTS			1988	36,315	239	10,20	239		35,263	20
21	BUILDINGS & IMPROVEMENTS			1989	164,241	7,313	10,20	7,313		125,384	21
22	BUILDINGS & IMPROVEMENTS			1990	64,734	3,237	20	3,237		43,114	22
23	BUILDINGS & IMPROVEMENTS			1992	11,222	224	10,20	224		9,866	23
24	BUILDINGS & IMPROVEMENTS			1993	37,801	1,987	5,10,20	1,987		25,556	24
25	BUILDINGS & IMPROVEMENTS			1994	9,466	382	5,20	382		5,456	25
26	BUILDINGS & IMPROVEMENTS			1995	99,649	6,990	5,10,15	6,990		62,919	26
27	BUILDINGS & IMPROVEMENTS			1996	33,788	1,256	5,20	1,256		17,650	27
28	BUILDINGS & IMPROVEMENTS			1997	403,089	19,561	5,10,20	19,561		144,934	28
29	BUILDINGS & IMPROVEMENTS			1998	107,004	5,614	5,10,20	5,614		32,300	29
30	BUILDINGS & IMPROVEMENTS			1999	3,684	368	10	368		1,658	30
31	FIRE PROTECTION BOXES ON LIGHTS			2000	23,606	1,180	20	1,180		3,541	31
32	TILE 1 WEST & S WEST HALLS			2000	4,633	232	20	232		695	32
33	DRYWALL SUNSET HALL			2000	4,600	230	20	230		460	33
34	TILE SUNSET HALL			2000	2,605	130	20	130		261	34
35	WNDOW BLINDS VALANCES 2 NORTH			2001	4,445	445	10	445		1,111	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SHADES FOR SCU CORNER WINDOWS	2001	$ 1,282	$ 128	10	$ 128	$	$ 321	37
38	GATES SCU	2001	1,685	112	15	112		281	38
39	NURSES STATION 2 NORTH	2001	1,550	78	20	78		194	39
40	AUTO DOOR SMOKE ROOM 1SW RESIDENTS	2001	2,596	260	10	260		649	40
41	NURSES FRONT DESK	2001	975	49	20	49		73	41
42	NW FRONT DOOR LOBBY AUTOMATIC WEST	2001	2,173	217	10	217		326	42
43	REROOF BOILER & CHILLER AREA	2001	9,415	942	10	942		1,412	43
44	COURT YARD GARDEN DOOR & ELECTRIC STRIKE	2002	3,422	342	10	342		513	44
45	HOLLOW METAL DOORS	2002	4,573	457	10	457		686	45
46	REROOF CHAPEL	2002	3,600	360	10	360		540	46
47	REROOF KITCHEN & CAFETERIA	2002	18,300	1,830	10	1,830		2,745	47
48	KITCHEN FREEZER DEFROSTER TIMER	2002	1,115	112	10	112		167	48
49	PLANK FLOOR 2ND FLOOR	2002	4,487	449	10	449		673	49
50	REMODEL BEAUTY SHOP	2002	4,722	472	10	472		708	50
51	CONVERT 366 & 368 TO 2 PRIVATE ROOMS	2002	8,771	219	20	219		219	51
52									52
53	FIXED EQUIPMENT	1971	814,827		25			814,827	53
54	FIXED EQUIPMENT	1972	253,064		25			253,063	54
55	FIXED EQUIPMENT	1978	280,726	5,373	25	5,373		280,726	55
56	FIXED EQUIPMENT	1979	13,938		10			13,938	56
57	FIXED EQUIPMENT	1984	23,531		10			23,531	57
58	FIXED EQUIPMENT	1985	117,689	5,615	5,10,15,20	5,615		108,561	58
59	FIXED EQUIPMENT	1986	15,456		10,15			15,455	59
60	FIXED EQUIPMENT	1987	12,320	320	10,15,20	320		11,066	60
61	FIXED EQUIPMENT	1988	8,162	241	10,20	241		7,122	61
62	FIXED EQUIPMENT	1989	4,670	311	15	311		4,512	62
63	FIXED EQUIPMENT	1993	259,307	14,040	10,20	14,040		144,004	63
64	FIXED EQUIPMENT	1995	188,017	9,657	10,15,20	9,657		79,259	64
65	FIXED EQUIPMENT	1996	10,809	1,037	10,15	1,037		7,125	65
66	FIXED EQUIPMENT	1997	35,461	1,812	15,20	1,812		11,467	66
67	FIXED EQUIPMENT	1998	180,143	9,222	15,20	9,222		50,641	67
68	FIXED EQUIPMENT	1999	8,744	526	15,20	526		2,012	68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,087,106	$ 263,113		$ 263,113	$	$ 4,698,215	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forwarc		$ 9,087,106	$ 263,113		$ 263,113	$	$ 4,698,215	1
2	SMOKE DETECTORS DINING ROOMS 2,3,4	2000	2,524	168	15	168		589	2
3	POWER WIRING UPGRADE EMERGENCY GENERATOR	2000	10,100	505	20	505		1,768	3
4	REPLACE SEPARATOR KITCHEN CHILLER	2000	2,720	136	20	136		476	4
5	NEW CHILLER REPLACEMENT	2000	208,923	10,446	20	10,446		36,562	5
6	KEYS LOCKS AND PULLS TO WINDOWS SCU	2000	2,160	144	15	144		504	6
7	SPEAKERS AMPS SCU	2000	2,546	170	15	170		339	7
8	TELEPHONE SYSTEM SCU	2000	2,695	270	10	270		539	8
9	REMOVE INSTALL BOILER CENTER SECTION	2000	11,787	786	15	786		1,572	9
10	UPGRADE SPRINKLER PIPING	2000	10,825	433	25	433		866	10
11	NURSE CALL SYSTEM 2 NORTH	2000	5,267	263	20	263		527	11
12	REPLACE 2 15HP CIRCULATION PUMP	2000	11,288	753	15	753		1,505	12
13	GENERATOR UPGRADE	2000	1,626	81	20	81		163	13
14	EXPANSION TANK BOILER	2001	2,780	185	15	185		463	14
15	FIRE ALARM NETWORKING	2001	2,041	102	20	102		255	15
16	CABLE WIRE 2 SOUTH COMPUTERS	2001	2,801	140	20	140		350	16
17	TOSHIBA VOICE MAIL SYSTEM	2001	5,156	516	10	516		1,289	17
18	SOUND SYSTEM FOR CHAPEL	2001	8,150	543	15	543		815	18
19	REPAIR FIRE SPRINKLER SYSTEM DEFECIENCIES	2001	4,715	189	25	189		283	19
20	REPLACED HOT WATER STORAGGE TANK	2001	3,150	158	20	158		236	20
21	NURSE CALL SYSTEM 3,4 NORTH	2001	11,826	591	20	591		887	21
22	5 TON ROOFTOP KITCHEN AIR CONDITIONER	2002	6,100	610	10	610		915	22
23	CHILLER SE WING	2002	26,230	1,749	15	1,749		2,623	23
24	90 SMOKE DETECTORS	2002	1,756	117	15	117		176	24
25	SPRINKLER SYSTEM REPAIR	2002	2,980	119	25	119		179	25
26	REPLACED AIR SEPARATOR	2002	2,810	187	15	187		281	26
27	REPLACED CENTER BOILER SECTION	2002	5,328	355	15	355		533	27
28	11 DOORS SPECIAL LOCKING UNITS	2002	24,522	817	15	817		817	28
29	NEW DOOR OPERATOR HW WEST ELEVATOR	2002	3,600	90	20	90		90	29
30	2 CENTER SECTION BOILER #3	2002	4,950	165	20	165		165	30
31	CONVECTION OVEN	2002	3,328	111	15	111		111	31
32	INTERMEDIATE SECTION BOILER	2003	5,300	177	15	177		177	32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,487,090	$ 284,189		$ 284,189	$	$ 4,754,270	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,487,090	$ 284,189		$ 284,189	$	$ 4,754,270	1
2	HW ELEVATOR WEST	2003	44,290	1,107	20	1,107		1,107	2
3	4TH FLOOR SMOKE DETECTORS	2003	3,231	108	15	108		108	3
4	5 PANIC HARDWARE WITH SWITCHES	2003	3,750	125	15	125		125	4
5	CABLE FOR ELEVATOR	2003	4,226	106	20	106		106	5
6	BOILER PLANT NEW PIPING & CONTROLS 90%	2003	16,754						6
7	BOILER REPAIR #2	2003	4,317	144	15	144		144	7
8									8
9	LAND IMPROVEMENTS	1975	2,807		25			2,807	9
10	LAND IMPROVEMENTS	1978	495		10			495	10
11	LAND IMPROVEMENTS	1979	6,425		10			6,425	11
12	LAND IMPROVEMENTS	1992	56,865	30	10	30		56,865	12
13	LAND IMPROVEMENTS	1995	18,601	1,550	12	1,550		13,046	13
14	LAND IMPROVEMENTS	1997	4,800	192	25	192		1,248	14
15	LAND IMPROVEMENTS	1999	44,219	3,685	12	3,685		16,583	15
16	FIRE HYDRANT INSTALLATION	2000	5,383	359	15	359		2,871	16
17	LANDSCAPE WHITE ROCK 4TH STREET	2000	3,784	378	10	378		3,027	17
18	LANDSCAPE YARD	2000	1,700	170	10	170		1,360	18
19	IRIGATION SYSTEM	2000	3,692	148	25	148		369	19
20	REMOVE REPLACE CONCRETE	2000	3,000	200	15	200		500	20
21	SHRUBS LANDSCAPING	2001	1,952	195	10	195		488	21
22	CONCRETE WORK	2003	8,404	280	15	280		280	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	ROUNDING		(4)	(2)		(2)		(4)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,725,781	$ 292,964		$ 292,964	$	$ 4,862,220	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 568,778	$ 54,784	$ 54,784	$	5 TO 25	$ 307,501	71
72	Current Year Purchases	53,927	4,156	4,156		5,10,15	4,156	72
73	Fully Depreciated Assets	272,581					272,581	73
74								74
75	TOTALS	$ 895,286	$ 58,940	$ 58,940	$		$ 584,238	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINTENANCE	1997 3/4 TON GMC & PLOW	1997	$ 23,521	$ 198	$ 198	$	4,5	$ 23,521	76
77	RESIDENT TRANSPORT	2001 E-450 FORD BUS	2001	56,836	11,367	11,367		5	17,051	77
78	RESIDENT TRANSPORT	1994 FORD VAN	1995	36,216				4	36,216	78
79										79
80	TOTALS			$ 116,573	$ 11,565	$ 11,565	$		$ 76,788	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,926,347	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 363,469	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 363,469	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,523,246	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	VILLA INDEP LIVING UNITS	$ 1,685,664	$ 41,246	$ 623,115	86
87	SUNSET APARTMENTS	2,613,061	11,014	11,014	87
88					88
89					89
90					90
91	TOTALS	$ 4,298,725	$ 52,260	$ 634,129	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

COMMUNITY COLLEGE TRAINS AIDES
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 76,684	$ 154		$ 76,838	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			9,350	758		10,108	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			53,742	3,546		57,288	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				36,910		36,910	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 139,776	$ 41,368		$ 181,144	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/01/02 **Ending:** 09/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 09/30/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 109,631	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	566,256		3
4	Supply Inventory (priced at COST)	56,706		4
5	Short-Term Investments	518,291		5
6	Prepaid Insurance	68,979		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,319,863	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	124,887		12
13	Land	188,707		13
14	Buildings, at Historical Cost	9,725,781		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,011,859		16
17	Accumulated Depreciation (book methods)	(5,523,246)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,026,461		21
22	Other Long-Term Assets (sp SEE ATTACHED	5,752,840		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,307,289	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,627,152	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 300,762	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	482,109		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SUNSET APARTMENTS	59,820		36
37	INS RESERVE & HEALTH CLAIMS	97,400		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 940,091	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	REF FEES & DEFERRED REVENUE	138,838		43
44	SUNSET APARTMENTS	3,001,084		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,139,922	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,080,013	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,547,139	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,627,152	$	48

***(See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,182,516	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,182,516	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(635,377)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (635,377)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,547,139	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 8,215,195	1
2	Discounts and Allowances for all Level	(949,361)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,265,834	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop	718	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space	3,875	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,593	23
	D. Non-Operating Revenue		
24	Contributions	347,869	24
25	Interest and Other Investment Income**	115,683	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 463,552	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	SEE ATTACHED	231,790	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 231,790	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,965,769	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,822,911	31
32	Health Care	4,017,591	32
33	General Administratior	2,031,965	33
	B. Capital Expense		
34	Ownership	443,908	34
	C. Ancillary Expense		
35	Special Cost Centers	193,338	35
36	Provider Participation Fee	91,433	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,601,146	40
41	**Income before Income Taxes (line 30 minus line 40)****	(635,377)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (635,377)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,102	2,318	$ 57,656	$ 24.87	1
2	Assistant Director of Nursing	1,409	1,538	31,384	20.41	2
3	Registered Nurses	16,889	18,414	318,072	17.27	3
4	Licensed Practical Nurses	75,844	82,934	1,189,178	14.34	4
5	Nurse Aides & Orderlies	148,690	161,134	1,501,032	9.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	17,723	19,762	221,612	11.21	8
9	Activity Director	1,747	1,894	25,891	13.67	9
10	Activity Assistants	11,053	12,102	94,788	7.83	10
11	Social Service Worker	5,731	6,349	62,461	9.84	11
12	Dietician					12
13	Food Service Supervisor	1,891	2,086	34,666	16.62	13
14	Head Cook	1,802	2,086	28,345	13.59	14
15	Cook Helpers/Assistants	46,903	50,912	398,482	7.83	15
16	Dishwashers	5,640	6,384	56,218	8.81	16
17	Maintenance Worker	11,240	12,253	133,068	10.86	17
18	Housekeepers	26,607	29,264	222,720	7.61	18
19	Laundry	3,726	4,125	36,261	8.79	19
20	Administrator	1,902	2,086	79,007	37.87	20
21	Assistant Administrator					21
22	Other Administrative	7,374	8,196	134,094	16.36	22
23	Office Manager					23
24	Clerical	13,775	15,629	159,211	10.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,687	4,033	37,782	9.37	31
32	Other Health C: SEE ATTACHED	8,408	9,086	92,490	10.18	32
33	Other(specify) SEE ATTACHED	4,108	4,410	73,316	16.62	33
34	TOTAL (lines 1 - 33)	418,251	456,995	$ 4,987,734 *	$ 10.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,026	1-3	35
36	Medical Director		3,600	10-3	36
37	Medical Records Consultant		1,475	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,232	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,950	11-3	44
45	Social Service Consultant		1,950	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,233		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY KIRLIN	CEO/ADMIN	0	$ 79,007
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 79,007

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
TIMOTHY J WIEWEL CPA	AUDIT/ACCTG	$ 13,350
SCHOLZ LOOS PALMER SIEBER	LEGAL	5,948
SCHOLZ LOOS PALMER SIEBER	LEGAL	494
FROST & RUTTENBERG	MEDICARE ACCTG	5,170
KLINGER & ASSOC	ENGINEERING	12,200
LZT HEALTHCARE	DESIGN STUDY	2,594
ARCHITECHNICS	ENGINEERING	962
SPARROW PLUMBING	PLUMBING	5,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 45,718

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 294,918
Unemployment Compensation Insurance	27,999
FICA Taxes	370,117
Employee Health Insurance	418,538
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	117,309
EMPLOYEE AWARDS	20,834
PHYSICALS	4,152
VACATION PERSONAL TIME	36,439
DISABILITY INSURANCE	5,693
LESS FUND DEVELOPMENT	(11,984)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,284,015

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,719
Health Care Worker Background Check	
(Indicate # of checks performed 77)	539
LIFE SERVICES NETWORK DUES	9,754
TRI STATE HEALTH COALITION	3,232
OTHER DUES FEES	6,632
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,876

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	11,917
PAID FY 2002 2003 SEMINAR	1,466
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,383

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/01/02 Ending: 09/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **NO**

(2) Are there any dues to nursing home associations included on the cost repor **YES**
If YES, give association name and amount **LIFE SERVICES NETWORK $7,954**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **NO** If YES, have these cost
been properly adjusted out of the cost report

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year? **YES** If YES, what is the capacity? **220**

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this perio **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **68,752** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports? **YES** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **NO**
If YES, give effective date of leas

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **91,433**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee? **YES** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **N/A**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **0** Has any meal income been offset agains
related costs? **YES** Indicate the amount $ **30,000**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **NO**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **NO** If YES, please indicate the amount of income earned from such
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patient **0**
d. Have vehicle usage logs been maintained **YES**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing suc
transportation during this reporting period $ **0**

(17) Has an audit been performed by an independent certified public accounting firm **YES**
Firm Name: **TIMOTHY J WIEWEL CPA** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **YES** If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **YES**
Attach invoices and a summary of services for all architect and appraisal fee

SUNSET HOME #0011643
COST CENTER SCH V
10/01/02-9/30/03

	SALARY 1	SUPPLIES 2	OTHER 3	TOTAL 4	RECLASS 5	RECLASS TOTAL 6	ADJUST 7	ADJUSTED TOTAL 8
LINE 43-OTHER								
FUND DEVELOP.			79,459	79,459	11,984	91,443	(91,443)	0
SUNSET APARTMENTS			38,942	38,942	36,252	75,194	(75,194)	0
VILLA			38,027	38,027	41,246	79,273	(79,273)	0
	0	0	156,428	156,428	89,482	245,910	(245,910)	0

SUNSET HOME #0011643 10/01/02-9/30/03

XIX SUPPORT SCHEDULE C. PROFESSIONAL SERVICES

		AMOUNT	INVOICES ATTACHED	
SCHOLZ LOOS PALMER SIEBERS	LEGAL	5,498	X	
ARCHITECHNICS	ENGINEERING	963	X	MISC CONSULTING HEATING & COOLING
KLINGER & ASSOCIATES	ENGINEERING	4,000	X	ADDITIONAL INDEP LIVING - PROJECT NOT DONE
KLINGER & ASSOCIATES	ENGINEERING	7,000	X	ASSISITED LIVING - PROJECT NOT DONE
KLINGER & ASSOCIATES	ENGINEERING	1,200	X	STORAGE BUILDING- PROJECT NOT DONE
LZT ASSOCIATES	ENGINEERING	2,594	X	PRELIMINARY HEALTHCARE RENOVATION
SPARROW PLUMBING	PLUMBING	5,000	X	CROSS CONNECTION INSPECTION FEES

SUNSET HOME
#0011643
10/01/02-9/30/03

XVII INCOME STATEMENT LINE 28 OTHER REVENUE

GAIN ON SALE OR DISPOSITION OF ASSETS	300
VILLA INDEPENDENT LIVING	160,991
SUNSET APARTMENTS RENTAL FEES	66,951
MISCELLANEOUS INCOME	3,548
	231,790

XX GENERAL INFORMATION LINE 12

HOUSEKEEPING - LAUNDRY DIRECTOR 25% TO LAUNDRY 75% TO HOUSEKEEPING

SUNSET HOME #0011643 SEPTEMBER 30, 2003

An interest income offset is not applicable at 9/30/03 because of the following reasons.

1) There has been a loss from operations for the last eighteen years. So no additional monies have been generated from operations for investment purposes.

2) The majority of investments are derived from contributions and endowments.

3) There have been various construction projects over the past several years which were financed through contributions and investment income earned on such monies and/or borrowings.

SUNSET HOME #0011643
BALANCE SHEET- SCH XV
SEPTEMBER 30, 2003

	OPERATING
LINE 23-OTHER	
VILLA BUILDING & EQUIPMENT NET OF DEPRECIATION (623,115)	1,062,549
SUNSET APARTMENTS BUILDING & EQUIPMENT NET OF DEPRECIATION (11,014	3,052,047
ASSETS INTERNALLY (BOARD) DESIGNATED	334,088
ADDITIONAL LAND COSTS	395,311
LAND HELD FOR EXPANSION	908,845
	5,752,840

SUNSET HOME #0011643 10/01/02-9/30/03

XVIII STAFFING & SALARY COSTS

LINE 32 - OTHER	1 # OF HRS. ACTUALLY WORKED	2 # OF HRS. PAID AND ACCRUED	3 TOTAL SALARIES AND WAGES	4 AVERAGE HOURLY WAGE
NRS-SUPPLY COORDINATOR	1,505	1,705	19,430	11.40
NRS- TRANSPORTER	1,893	2,016	16,340	8.11
SOC SERV- DIRECTOR	1,771	1,951	26,725	13.70
NRS- CLERICAL	3,239	3,414	29,995	8.79
	8,408	9,086	92,490	
LINE 33 - OTHER				
HOUSEKEEPING & LAUNDRY DIRECTOR	1,946	2,080	24,605	11.83
MAINTENANCE DIRECTOR	1,918	2,086	43,073	20.65
ACTIVITIES- PASTORIAL CARE DIRECTOR	244	244	5,638	23.11
	4,108	4,410	73,316	